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Frequently Asked Questions
Medicare Therapy Cap – 2010 (document prepared 1/27/10)

As of January 1, 2010 there is an $1860 combined cap on physical therapy and speech language pathology services and a separate $1860 cap on occupational therapy services. There is no therapy cap exceptions process available after January 1, 2010. Congress would need to pass legislation to continue the exceptions process, which expired on December 31. When a patient exceeds the 2010 therapy cap limit of $1860, he or she will either need to pay out of pocket for therapy services exceeding the cap or receive these services from an outpatient hospital setting.

Below are some of the most common questions related to implementation of the therapy cap without an exceptions process. This document will be updated when Congress passes legislation regarding the therapy cap.

Q: What is the therapy cap amount for 2010?
A: The therapy cap amount for 2010 is $1860 for outpatient physical therapy and speech language pathology services combined. There is a separate $1860 cap for outpatient occupational therapy services. The cap is applicable to services provided to a Medicare beneficiary January 1, 2010-December 31, 2010.

Q: With the new cap of $1860 for Part B PT/SLP benefits, how does the cap count toward the patient responsibility of 20%? For example, in outpatient, the patient is responsible for 20% of allowable charges.
A: Medicare will pay 80% of the allowed charges ($1488.00) and the beneficiary will be responsible for the remaining 20% ($372.00)

Q: Where do I find information about the amount of dollars that my patient has accrued toward the therapy cap?
A: All providers and contractors may access the accrued amount of therapy services from the ELGA screen inquiries into CWF. Providers/suppliers may access the remaining therapy services limitation dollar amount through the 270/271 eligibility inquiry and response transaction. Providers who bill to FIs will find the amount a beneficiary has accrued toward the financial limitations on the HIQA. Some suppliers and providers billing to carriers may, in addition, have access to the accrued amount of therapy services from the ELGB screen inquiries into CWF. Suppliers who do not have access to these inquiries may call the contractor to obtain the amount accrued.

Q: Will there be a therapy cap exceptions process in 2010?
A: As of January 1, 2010, there is no exceptions process for the therapy cap. Congress needs to pass legislation to extend the exceptions process. APTA is vigorously lobbying Congress to pass legislation to repeal the therapy cap or at a minimum extend the exceptions process.

Q: If there is no exceptions process in 2010, what are my options for delivery of services to my Medicare patients who exceed the $1860 cap amount?
A: If Congress does not extend the exceptions process, Medicare beneficiaries have two options. They can either continue to receive services through their current physical therapists and pay for these services out of pocket or they can elect to receive services through an outpatient hospital department.

If the patient elects to pay out of pocket, it is advisable to obtain a signed Advanced Beneficiary Notice (CMS-R-131) (ABN) from the patient, although the use of the ABN is voluntary. Then the therapist can collect cash from the beneficiary or bill the patient's secondary insurance. The secondary insurance may require a denial from the Medicare program before it will cover these services. If a patient would like to continue to receive coverage under Medicare for outpatient physical therapy services he or she must be discharged and go to an outpatient hospital department to receive those services

Q: If a Medicare beneficiary chooses to continue treatment in a setting that is not an outpatient hospital, at what rate can the services be billed?
A: If the beneficiary chooses to continue treatment at a setting other than the outpatient hospital where medically necessary services may be covered, the services may be billed at the rate the provider/supplier determines. However, be aware that provision of free or deeply discounted services can potentially be a violation of the anti-kickback statutes.

Q: Have speech language pathologists been given their own cap or are they still combined with physical therapy? If so, why and what are the implications for physical therapists now that speech language pathologists have their own billing privileges under Medicare?
A: Speech language pathology services and physical therapy services are still combined under the same $1860 cap due to language included under the Medicare statutes. Prior to receiving their own billing benefit under the Medicare program in July 2009, services provided by speech language pathologists in skilled nursing facilities, home health agencies, and hospitals under the Part B benefit did accrue toward this cap and it did not appear to have a significant impact. Although we do not expect a significant difference due to the small number of speech language pathologists enrolled in private practice, the implications for the cap now that speech language pathologists are billing the Medicare program directly will need to be monitored.

Q: Why do the therapy caps not apply in outpatient hospital departments?
A: When Congress passed the Balanced Budget Act of 1997, outpatient hospital departments were excluded from the therapy cap. Congress wanted to create a "safety net" for Medicare patients who exceed the cap. There was no specific rationale for Congress choosing outpatient hospitals as the "exempt" setting.

Q: How do I determine if my facility is considered an outpatient hospital?
A: The outpatient hospital setting is exempt from the $1860 financial limitations. In order to bill the services through the main provider (hospital) and thus be exempt from the therapy limit, the facility must have provider based status. This means the relationship between the main hospital

and the provider based entity or department of the provider must meet certain requirements set forth in the Medicare regulations (42 CFR section 413.65). These requirements relate to common licensure; operation under the ownership and control of the main provider (e.g. same governing body; same bylaws, administration and supervision); location (e.g. must be within 35 miles of main provider or serve same patient population); integration of clinical services; financial integration; management contracts and other areas.

Q- Can a SNF resident receive services from an outpatient hospital after the cap has been exceeded?
A- Patients who are residents in a Medicare certified part of a SNF may not utilize outpatient hospital services for therapy services over the financial limits, because consolidated billing rules require all services to be billed by the SNF.

Q- Does the cap amount "re-set" for each diagnosis? For instance, if a patient receives PT services January-March for a hip replacement and is discharged, then returns in September as a result of a stroke, is there one cap for the first episode of treatment and a new cap for the second episode of treatment?
A- No, the therapy cap is an annual per beneficiary cap.

Q- If the cap exemption ends, and Medicare no longer is covering services beyond the cap, can we use GA/GY codes and bill the secondary insurance plans for reimbursement?
A- Yes. You should provide the beneficiary with an ABN explaining that services beyond the cap amount are not covered and submit the claim to Medicare with the modifier for a denial.

Q: Is it okay to offer Medicare patients an "aftercare" program if they use up the cap at a reduced rate or flat fee?
A: If a patient has exceeded the cap in 2010 and there is **no** exceptions process, a physical therapist can continue treatment; however, the beneficiary will be financially responsible for these services. CMS recommends that you give the beneficiary an Advanced Beneficiary Notice (ABN); however, it is not mandatory that you provide the beneficiary an ABN. If the patient exceeds the cap, the provider is not required to bill Medicare. If the service is statutorily non-covered, the claim could be submitted using the GY modifier indicating the service is non-covered by statute.

When charging patients out of pocket, it is very important to have a set fee schedule that applies to all patients regardless of their insurer (Medicare or private insurance). Additionally, any discounts offered should also be offered to all patients regardless of their source of insurance coverage and all discount policies should be established in writing. For instance, you may have a policy that offers a 20% discount to patients with income less that a certain dollar amount in a given year or for patients with medical costs that exceed a set limit in a given year.

Q: I am interested in obtaining information regarding application of the therapy to services furnished to Medicare beneficiaries in 2009. Where can I obtain that information?
A:http://www.apta.org/AM/Template.cfm?Section=Medicare1&Template=/MembersOnly.cfm&NavMenuID=528&ContentID=28914&DirectListComboInd=D

Q: Where can I find information on what is going on in Congress related to the therapy cap?
A:http://www.apta.org/AM/Template.cfm?Section=Therapy_Cap&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=188&ContentID=18639